

Health,  
& Welfare  
Public  
Service

S. 300  
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED DEC 30 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

318

1003

46445  
STATE FILE NUMBER

11853

Registration District No.

Primary Registration District No.

Registration District No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>St. Louis</u> TOWN			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR <u>University City</u> TOWN		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <u>DePaul Hosp</u> INSTITUTION			Length of stay in lb		d. STREET (If outside, give location) ADDRESS <u>6764 Bartmer Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Pansy</u> Middle <u>C</u> Last <u>Weber</u>				4. DATE OF DEATH Month <u>12</u> Day <u>9</u> Year <u>57</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18 1891</u>		9. AGE (In years last birthday) <u>66</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Frank Overstreet</u>				14. MOTHER'S MAIDEN NAME <u>Pauline Sieberth</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Orville Weber 6764 Bartmer Ave.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Carcinoma of left Breast with</u> DUE TO (c) <u>metastases</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>170x</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour <u>      </u> Month, Day, Year a. m. <u>      </u> p. m. <u>      </u>								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		20g. COUNTY		
20h. STATE								
21. I attended the deceased from <u>11/14/57</u> to <u>12/9/57</u> and last saw her <u>alive</u> on <u>12/8/57</u> Death occurred at <u>7:30a</u> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>George A. Carroll M.D.</u>				22b. ADDRESS <u>607 N. Grand</u>		22c. DATE SIGNED <u>12/10/57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>12-12-57</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>		
24. FUNERAL DIRECTOR ADDRESS <u>J.W. Clark F.H. 1125 Hodiamont</u>				25. DATE RECD. BY LOCAL REG. <u>DEC 10 57</u>		26. REGISTRAR'S SIGNATURE <u>Earl Smith M.D.</u>		

(Licensed Embalmer's Statement on Reverse Side)

---

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....

*Alfred J. Boedek*

Licensed Embalmer No. *266*

P. O. Address *1125 Hiram*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.